INDIANA STATE DEPARTMENT OF HEALTH

APPLICATION - SENIOR FARMERS' MARKET NUTRITION PROGRAM
State Form 53250 (4-07)

County _____ Date of Application ___/____/____

PARTICIPANT INFORMATION

First Name_____ Last Name_____

Address_____
Street City State/ZIP

Date of Birth ____/____/____ Household size _____ Sex ☐ M ☐ F

The collection of race and ethnicity is requested solely for the purpose of determining the State agency's compliance with Federal civil rights laws, and ensures that the program is administered in a non-discriminatory manner. Your responses to these questions will not affect consideration of your application. If you choose not to self-identify race and ethnicity, the person taking the application must record the participant's race and ethnicity based on visual observation.

ETHNICITY CATEGORY

- ☐ HISPANIC OR LATINO
- ☐ NOT HISPANIC OR LATINO

RACE CATEGORY (*select one or more*)

- ☐ AMERICAN INDIAN OR ALASKA NATIVE
- ☐ ASIAN
- ☐ BLACK OR AFRICAN AMERICAN
- ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
- ☐ WHITE
- ☐ MULTI-RACIAL (PLEASE SPECIFY ABOVE)

To be eligible to receive Senior Farmers Market Nutrition Program (SFMNP) checks, you must be at least 60 years of age and meet the income guidelines, which are based on 185% of the Federal Poverty Income Guidelines during the current fiscal year and live in the county where the checks are being issued. I have been given a copy of the current income guidelines for this fiscal year.

CURRENT PARTICIPANT

- ☐ Food Stamps
- ☐ TANF
- ☐ CFSP
- ☐ Member of a WIC Household

Monthly Income: _____ Income eligible? ☐ Yes ☐ No

Applicant eligible? ☐ Yes ☐ given SFMNP Checks ☐ Put on wait list

Issued SFMNP checks numbers _____through _____

☐ No If no; ☐ denial provided to client Date_____

PROXY

A proxy is a person only authorized to receive and/or redeem SFMNP checks. A proxy should be at least 18 years of age and dependable for the duration of the program months of operation. In order for the checks to be issued to a proxy, the proxy must be present identification as well as written approval from the participant. Proxies must sign the check register to receive checks. Proxies have the same obligations to follow program guidelines when purchasing fruits and vegetables from an authorized farmer.

I, _____ authorize the following individual(*s*) to act as my proxy.
Participant signature

Assigned proxies: _____ _____
1st proxy named 2nd proxy named

☐ **Check here if no proxy was assigned**

CERTIFICATION BY PARTICIPANT

I have been advised of my rights and obligations for use of SFMNP Checks. I certify that that the information I have provided for my eligibility determination is correct, to the best of my knowledge. I am aware that I cannot receive farmers' market benefits from more than one state or more than one local agency. This application is being submitted in connection with the receipt of Federal assistance. Program officials may verify information on this form. I understand that intentionally making a false or misleading statement or intentionally misrepresenting, concealing, or withholding facts may result in paying the State agency, in cash, the value of the food benefits improperly issued to me and may subject me to civil or criminal prosecution under State and Federal law. Standards for eligibility and participation in the Indiana SFMNP program are the same for everyone, regardless of race, color, national origin, age, disability or sex. I understand that I may appeal any decision made by the local agency regarding my eligibility for the SFMNP program. I certify I meet the 2007 household size and income guidelines provided by the state and that I am eligible to receive SFMNP benefits.

_____ _____
Signature of Participant Date

_____ _____
Signature of Staff/Volunteer Date

Do you or any adult household members have:

☐ Diabetes ☐ Arthritis ☐ Osteoporosis ☐ Cancer ☐ Asthma

☐ COPD ☐ Obesity (*more than 15 lbs overweight*) ☐ High Blood Pressure

☐ Heart Disease ☐ Other: Please list: _____

Are you participating in other food programs? ☐ YES ☐ NO If yes, please indicate all that apply:

☐ Commodities ☐ Local food bank ☐ Food Stamps ☐ Emergency food (TFAP)
☐ Other, please list: _____

"This institution is an equal opportunity provider and employer."